

**PATIENT INFORMATION:**

Name of Patient/Previous Names \_\_\_\_\_ Birth Date \_\_\_\_\_ Medical Record Number \_\_\_\_\_  
 Street Address \_\_\_\_\_ City, State, Zip \_\_\_\_\_ Phone Number \_\_\_\_\_

**AUTHORIZES DISCLOSURE BY:**

ProHealth Care Oconomowoc Memorial Hospital       ProHealth Care Waukesha Memorial Hospital  
 ProHealth Care Behavioral Health Services       ProHealth Works, Specify Site \_\_\_\_\_  
 PHMG, Specify Clinic/Provider \_\_\_\_\_       ProHealth Solutions Participant \_\_\_\_\_  
 Other (Name of Health Care Provider/Plan/Other): \_\_\_\_\_  
 Street Address \_\_\_\_\_ City, State, Zip Code \_\_\_\_\_

**DISCLOSURE OF HEALTH INFORMATION TO:**

Name of Health Care Provider/Plan/Other \_\_\_\_\_  
 Street Address \_\_\_\_\_ City, State, Zip Code \_\_\_\_\_

**INFORMATION TO BE DISCLOSED:**

CLINIC		HOSPITAL	
<input type="checkbox"/> Clinic Records 2-3 Year Summary (general abstract includes Progress Notes, Consults, Labs & Radiology Reports)		<input type="checkbox"/> Hospital Summary (general abstract includes Discharge Summary, H&P, Consults, Operative Reports, Labs, Radiology Reports and ED Report)	
<input type="checkbox"/> Entire Medical Record	<input type="checkbox"/> Mental/Behavioral Health	<input type="checkbox"/> Entire Medical Record	<input type="checkbox"/> Mental/Behavioral Health
<input type="checkbox"/> History & Physical	<input type="checkbox"/> Radiology Films	<input type="checkbox"/> History & Physical	<input type="checkbox"/> Radiology Films
<input type="checkbox"/> Office Visit Notes	<input type="checkbox"/> Radiology Report	<input type="checkbox"/> Consultation	<input type="checkbox"/> Radiology Report
<input type="checkbox"/> Operative/Procedure Report	<input type="checkbox"/> Rehab Notes (PT, OT, Speech)	<input type="checkbox"/> Operative/Procedure Report	<input type="checkbox"/> Rehab Notes (PT, OT, Speech)
<input type="checkbox"/> Laboratory Report	<input type="checkbox"/> Billing Records	<input type="checkbox"/> Discharge Summary	<input type="checkbox"/> Billing Records
<input type="checkbox"/> Pathology Report		<input type="checkbox"/> Laboratory Report	<input type="checkbox"/> Pathology Report
<input type="checkbox"/> Other _____		<input type="checkbox"/> Other _____	

**DISCLOSURES REQUIRING SPECIAL CONSENT:** In compliance with Wisconsin Statutes which require special permission to disclose otherwise privileged information, I am authorizing that the following information also be disclosed. Check all that apply.  HIV/AIDS\*    Drug/Alcohol Abuse/Treatment    SANE    SANE Photos

**FOR THE FOLLOWING DATES:** From: \_\_\_\_\_ To: \_\_\_\_\_

**PURPOSE FOR DISCLOSURE:** Please provide specific purpose for disclosure or check applicable category.

Continuing Care    Transfer to New Provider    Insurance/Claim Purposes    Legal    Personal Use  
 Disability Determination    Workers Compensation    Vocational Rehab Eval  
 Other \_\_\_\_\_

Check One:  Verbal Release    Paper Release    View    Electronic/Digital Release (specify) \_\_\_\_\_

Release by:  US Mail    MyChart    Fax \_\_\_\_\_       Pick-Up: Location \_\_\_\_\_

PATIENT LABEL



**YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION:**

**Right to Inspect or Receive a Copy of the Health Information to Be Used or Disclosed** – I understand that I have the right to inspect or receive a copy (may be provided at a reasonable fee) of the health information I have authorized to be used or disclosed by this authorization form.

**Right to Receive Copy of This Authorization** – I understand that if I agree to sign this authorization, I may receive a copy.

**Right to Refuse to Sign This Authorization** – I understand that I am under no obligation to sign this form and that ProHealth Care may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on my decision to sign this authorization except regarding a) research related treatment, b) health plan enrollment or eligibility, c) the provision of health care that is solely for the purpose of creating PHI for disclosure to a third party.

**Right to Withdraw This Authorization** – I understand that I have the right to withdraw this authorization at any time by providing a written statement of withdrawal to ProHealth Care's Release of Information Department. I am aware that my withdrawal will not be effective as to uses and/or disclosures of my health information that the person(s) and or organizations(s) listed above have already made in reference to this authorization. I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure and no longer protected by Federal privacy standards.

**\*HIV Test Results:** I understand my HIV test results may be released without authorization to persons/organizations that have access under State laws and a list of those persons/organizations is available upon request.

**Copy or Facsimile (FAX) Valid as an Original.**

This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

**EXPIRATION DATE:** This authorization is effective until \_\_\_\_\_ or 6 months from the date signed, and includes records that were created or existed on or before the date this authorization was signed.

This includes records that are created after the date this authorization is signed, up until the expiration date.  
\_\_\_\_\_(initials)

**SIGNATURE OF PATIENT/LEGAL REP:** \_\_\_\_\_ **DATE:** \_\_\_\_\_ **TIME:** \_\_\_\_\_

If signed by a person other than the patient, complete the following:

1. Individual is:  a minor  legally incompetent or incapacitated  deceased
2. Legal authority:  parent\*  legal guardian  next of kin/executor of deceased  activated POA for Health Care

\*By signing above, I hereby declare that I have not been denied physical placement of this minor child.

Information Released By: \_\_\_\_\_ **DATE:** \_\_\_\_\_ **TIME:** \_\_\_\_\_

Number of Pages Released: \_\_\_\_\_

PATIENT LABEL

